Auditor's Description of Condition
DSHS Response
Laws & Regulations

The Department of Social and Health Services, Medical Assistance Administration does not ensure that providers of motorized wheelchairs have the documentation required to substantiate claims for payment.

Background

Durable medical equipment is equipment that can withstand repeated use, is primarily used for a medical purpose, is generally used by a person with injury or illness, and is appropriate for use in the home. Some durable medical equipment, such as canes, walkers, crutches and wheelchairs, can give a person more mobility and greater independence.

An April 2004 report of the U. S. General Accounting Office (GAO) stated Medicare spending for power wheelchairs, one of the program's most expensive items of equipment, rose 450 percent from 1999 through 2003. However, Medicare has reported only an 11 percent increase in overall spending for the same period. This spending growth for power wheelchairs has raised concerns that Medicare may have made improper payments to providers of motorized wheelchairs.

These concerns may apply to Medicaid, which also pays claims for power wheelchairs. Between January 1 and December 31, 2003, the state Medicaid program paid over $1 million to 104 providers for motorized wheelchairs with programmable controls.

In this state, a Medicaid provider must obtain specific documentation to substantiate a patient's need for such a wheelchair. This documentation includes a prescription signed by a physician or other licensed health practitioner, proof of medical necessity, and the patient's confirmation of delivery. In addition, prior authorization by the Administration is required for some wheelchair claims as follows:

- Provider claims with five or more line items to be paid totally by Medicaid require support documentation prior to authorization.

- Provider claims with less than five line items may be communicated by phone prior to authorization. However, written documentation eventually must be provided.

Claims paid by both Medicare and Medicaid, with Medicare as the primary payer, require no prior authorization.

According to Medicaid eligibility requirements, the estimated length of need for a patient cannot exceed six months; after that time, the need must be re-evaluated.

Description of Condition

We attempted to determine compliance with the documentation requirements for providers of motorized wheelchairs. Because the Department of Social and Health Services, Medical Assistance Administration, does not receive or maintain these records, we performed on-site reviews of the payment support documentation for 90 claims submitted by three providers of power wheelchairs.

While all of the claims tested had the required proofs of delivery, none of the three providers was able to produce all of the other required documentation to substantiate their claims for payment by Medicaid.

- None of the 90 claims had prescriptions that conformed to all Medicaid requirements.

- Nine of the 90 claims did not have the required proofs of medical necessity.

- Additionally, all of the documents we reviewed indicated a length of need exceeding six months.

Cause of Condition

- Providers of power wheelchairs may be unsure of the documentation required for payment, due to the difference in the support requirements between Medicare and Medicaid.

- The Administration has no standardized forms for prescriptions and proof of medical necessity for providers.

- While the Administration stated it reviews a selected number of wheelchair claims, it does not review any claims paid by both Medicare and Medicaid**.** In an e-mail to our office, the Administration stated:

> The primary reason for this is that Medicare...payment and coverage rules are significantly different from Medicaid. If Medicaid were to include crossover claims in an audit or post-payment review sample, those claims could not be reviewed per Medicaid rules/billing instructions. Medicaid auditors lack the detailed knowledge of the Medicare program and the authority to audit Medicare paid claims.

Effect of Condition

This condition increases the risk that providers could submit fraudulent requests for payment that would not be detected in a timely manner, if at all. The cost associated with the ninety claims we tested was $115,282, of which $57,641 was paid with federal funds and an equal amount with state funds.

Recommendations

We recommend that the Administration:

- Ensure its providers are familiar with the differences in documentation requirements for Medicare and Medicaid.

- Standardize prescription and proof of medical necessity forms to facilitate compliance by providers.

- Establish controls to perform adequate reviews of payment support documentation prior to making payments for motorized wheelchairs. Ensure reviews include verification of allowability for the Medicaid portion of costs paid for with both Medicaid and Medicare funds.

- Work with the U.S. Department of Health and Human Services to determine if any unsupported costs charged to Medicaid must be returned.

Department's Response

The Department does not concur with this finding.

Medical Assistance Administration (MAA) currently reviews Medicaid-only requests for wheelchairs through a prior authorization process, and files are kept.

- The 90 claims reviewed by the auditors appear to be claims that involved dual-eligible clients (enrolled in both Medicare and Medicaid). Those claims are paid through our system as a "Medicare cross-over" – claims that are only reimbursed for applicable co-pays and deductibles -- and no prior authorization review is performed. Suppliers are bound by primary payer rules – in these cases, Medicare-- not Medicaid.

- Since these claims were paid as a Medicare cross-over, the Department feels that the suppliers met their documentation and billing requirements as defined by Medicare as a primary payer and Medicaid as a secondary payer.

- There is no length-of-need requirement in federal guidelines. The eligibility requirements cited by SAO with regard to length-of-need appear to be a misreading of the Washington Administrative Code. As written, WAC 388-543-1100 (1d) refers to a period not to exceed six months, but the reference actually means the client's condition should be re-evaluated after six months. It would be counterintuitive to interpret the reference to mean the Department will only buy wheelchairs for clients whose need is temporary. In fact, the Department requires the opposite – i.e., the need for a power wheelchair must exceed six months before it can be purchased.

- The Administration reviews every request for a Medicaid-only client through a prior authorization process. The reports should differentiate which statements refer to a payment for a Medicare/Medicaid client and which statements refer to a Medicaid-only client. The Department is in the process of developing a standardized prescription form to be used for requests from Medicaid-only clients. We also will look at the need to have a standardized proof-of-delivery form.
- The SAO appears to be recommending a prior authorization or pre-pay process be developed for dual-eligible clients as well as Medicaid-only clients. The Department feels additional research would be needed to determine whether that would be cost effective.
- Given this additional information, the Department is unsure of what expenditures need to be recovered.

Auditor's Concluding Remarks

Applicable Laws & Criteria

WAC 388-543-1225 states:

Provider requirements.

(1) Providers and suppliers of durable medical equipment (DME) and related supplies, prosthetics and orthotics, medical supplies and related items must meet the general provider documentation and record retention requirements in WAC 388-502-0020. In addition to these requirements, the medical assistance administration (MAA) requires providers to furnish, upon request, documentation of proof of delivery as stated in subsections (2) and (3) of this section.

(2) When a provider delivers an item directly to the client or the client's authorized representative, the provider must be able to furnish proof of delivery when MAA requests that information. All of the following apply:

(a) MAA requires a delivery slip as proof of delivery, and it must:

(i) Be signed and dated by the client or the client's authorized representative (the date of signature must be the date the item was received);

(ii) Include the client's name and a detailed description of the item(s) delivered, including the quantity and brand name;

WAC 388-502-0100 states:

General conditions of payment.

(1) The department reimburses for medical services furnished to an eligible client when all of the following apply:

(a) The service is within the scope of care of the client's medical assistance program;

(b) The service is medically or dentally necessary;

(c) The service is properly authorized;

WAC 388-543-1100 states:

Scope of coverage and coverage limitations for DME and related supplies, prosthetics, orthotics, medical supplies and related services.

The federal government deems durable medical equipment (DME) and related supplies, prosthetics, orthotics, and medical supplies as optional services under the Medicaid program, except when prescribed as an integral part of an approved plan of treatment under the home health program or required under the early and periodic screening, diagnosis and treatment (EPSDT) program. The department may reduce or eliminate coverage for optional services, consistent with legislative appropriations.

(1) The medical assistance administration (MAA) covers DME and related supplies, prosthetics, orthotics, medical supplies, related services, repairs and labor charges when all of the following apply. They must be:

(a) Within the scope of an eligible client's medical care program;

(b) Within accepted medical or physical medicine community standards of practice;

(c) Prior authorized as described in WAC 388-543-1600;

(d) Prescribed by a qualified provider, acting within the scope of the provider's practice. The prescription must state the specific item or service requested, diagnosis, prognosis, estimated length of need (weeks or months, not to exceed six months before being reevaluated), and quantity;

(e) Billed to the department as the payor of last resort only. MAA does not pay first and then collect from Medicare;.....

.....(10) MAA covers the following categories of medical equipment and supplies only when they are medically necessary, prescribed by a physician or other licensed practitioner of the healing arts, are within the scope of his or her practice as defined by state law, and are subject to the provisions of this chapter and related WACs:

(a) Equipment and supplies prescribed in accordance with an approved plan of treatment under the home health program;

(b) Wheelchairs and other DME;.....